# COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
# PROGRAM SUPPORT BUREAU – QUALITY ASSURANCE DIVISION
# LEGAL ENTITY QUALITY ASSURANCE REPORT (LEQAR)

**DATE:** _____ **INITIAL REPORT:** ☐ **ANNUAL REPORT:** ☐

**LEGAL ENTITY NAME:** _____ **LEGAL ENTITY NUMBER:** _____

**RESPONSIBLE PERSON:** _____ **LEAD DISTRICT CHIEF:** _____

**Print name/Position/Tile**

**TELEPHONE NUMBER:** _____ **EMAIL ADDRESS:** _____

| QUALITY ASSURANCE REQUIREMENT SECTION | FINDING | COMMENT Attached |
|---|---|---|
| 1. Does your agency have a written Quality Assurance (QA) process? | ☐ Yes - If your answer is **Yes**, attach a copy of the written QA process<br>☐ No - If the answer is No, attach a **Corrective Action Plan (CAP)**<br>☐ No change from last report* | |
| 2. Does your agency conduct an annual chart review on at least 5% of open clinical records per quarter? | ☐ Yes ☐ No - If the answer is No, attach a CAP<br>☐ No change from last report* | |
| 3. Does your agency use a standard QA tool to review charts? | ☐ Yes - If the answer is yes, please attach a copy of the tool<br>☐ No - If the answer is No, attach a CAP | |
| 4. Does your agency have a formal QA committee meeting – if so, how often? | ☐ Yes ☐ No ☐ Weekly ☐ Monthly<br>☐ Quarterly Other: _____ ☐ No change from last report* | |
| 5. Does your agency have one or more clinical staff specifically assigned to QA? | ☐ Yes ☐ No | |
| 6. Does your agency have a process in place for using the QA review findings to inform and improve ongoing documentation practices? | ☐ Yes - If the answer is **Yes**, attach a description of the QA process<br>☐ No - If the answer is No, attach a CAP ☐ No change from last report* | |
| 7. Aside from chart reviews, what other QA activities does your agency do? Please check all applicable activities? | ☐ Case Reviews ☐ QA/QI Meetings ☐ Medication Monitoring<br>☐ Training time for Medi-Cal/QA requirements<br>☐ Personnel time related to State & Auditor Controller Audits | |
| 8. Does your agency use the LAC-DMH Quality Assurance Guidelines? | ☐ Yes ☐ No ☐ No change from last report | |
| 9. Does your agency use the DMH Short–Doyle Medi-Cal Organizational Provider's Manual? | ☐ Yes ☐ No ☐ No change from last report<br>If the answer is No, attach an explanation and a CAP | |
| 10. Does your agency use the Guide to Procedure Codes for Claiming MH services? | ☐ Yes ☐ No ☐ No change from last report<br>If the answer is No, attach a CAP | |
| 11. When was the last time your agency were audited by the Auditor Controller? | Date of Last Audit:_____ ☐ Unknown<br>☐ Never been audited | |

| QUALITY ASSURANCE TRAINING/COMMUNICATION SECTION | FINDING | COMMENT Attached |
|---|---|---|
| 12. Does your agency conduct QA related trainings for your staff? | ☐ Yes ☐ No | |
| 13. Does your agency send staff to DMH provided trainings, e.g. DMH Basic Documentation Training? | ☐ Yes ☐ No | |
| 14. Approximately what percentage of your agency's clinical staff received some form of QA related training last year? | _____% of clinical staff received QA related training | |
| 15. Which Services Area QIC/QAC does you agency attend? Please check all Service Areas that applies and list the name and title of staff that attends the meeting. | ☐ SA1 Staff: _____ ☐ SA2 staff: _____<br>☐ SA4 Staff: _____ ☐ SA4 staff: _____<br>☐ SA5 Staff: _____ ☐ SA6 staff: _____<br>☐ SA7 Staff: _____ ☐ SA8 staff: _____<br>☐ No - If the answer is No, attach a CAP | |
| 16. Do you interact with the Service Area Quality Assurance Liaisons? | ☐ Yes ☐ No | |
| 17. Do you access the Program Support Bureau/QA Website or the LAC-DMH Internet site for QA information and updates? | ☐ Yes ☐ No | |

**(*) Do not use this response for the Initial report – Use this response for subsequent reports. If you have any questions regarding this form, please contact your Service Area QA Liaison or Service Area QA Lead, or email your question to QA@dmh.lacounty.gov.**

**I understand that the information provided above is subject to review and audit. I have made a good faith effort to ensure the accuracy of the above answers and I certify to the best of my knowledge and belief that these answers are true and correct.**

_____ _____ _____ _____

**Signature of Responsible Person** **Date** **Reviewed by QA Lead/Supervisor** **Date**

**Report Status:** ☐ **Complete** ☐ **Incomplete - Return to Legal Entity**

_____

**Print Name of Responsible Person**

**GENERAL INFORMATION**

1. The LACDMH is responsible for the oversight of the Mental Health Plan and the QA processes as they relate to Medi-Cal documentation and claiming requirements for DMH Legal Entities.
2. The Legal Entity must have a quality assurance process in place (must be written and on file with LAC- DMH Quality Assurance Division) to ensure that all documentation requirements of the Organizational Provider's Manual are met and occur within the established timeframes as set forth within LACDMH Policy No. 104.09 (Policy No. 104.09 is obtainable from the LAC-DMH QA website:http://psbqi.dmh.lacounty.gov/)
3. The LAC DMH requires Legal Entity to complete the **Contract Provider Quality Assurance Report (CPQAR)**. The **CPQAR** will be used to establish to the LACMHP the Legal Entity's QA effectiveness, quality of care and service delivery.
4. The CPQAR will demonstrate to the Federal, State and County Auditors that LACDMH monitors and reviews QA processes of LAC-DMH Legal Entity.

**GENERAL INSTRUCTIONS**

5. The **CPQAR** is to be completed annually and sent to the LAC DMH QA Division on or before January 15th annually. Send the C**PQAR** and attachments to: **LAC-DMH PSB-QA, 695 Vermont Ave - 15th floor, Los Angeles, CA 90005 or send via email to: QA@dmh.lacounty.gov**
6. If CPQAR directs you to complete a Corrective Action Plan (CAP), use the attached Corrective Action Plan Form and submit with your CPQAR.
7. The QA Lead or Supervisor will review the **CPQAR;** if the report is incomplete, the reviewer will mark the CPQAR as "Report Incomplete" and will contact the Legal Entity's "Responsible Person". The updated **CPQAR should be returned within 10 business days from the date of receipt**. If significant revisions are made to the QA written process, state on your document the following: "Revised on 0/0/2014"and send a copy of the updated QA process to the LACDMH QA Division.